MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

04908

CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Mo
Hospital, institution, or street address where death occurred: Hollingsworth Manor. #28.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. #28 Hollingsworth Manor.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Norma Jean Baldwin

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan 12, 1945

8. AGE:

Years	Months	Days	If less than one day
	4	27	hrs. min.

9. Birthplace: Frostdale, Va (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: Charles Baldwin
13. Birthplace: Whitetop Va
MOTHER 14. Maiden name: Hazel Sanders
15. Birthplace: Frostdale Va
16. Informant: Charles Baldwin
Address: #28 Hollingsworth Manor Elkton, Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 9 1945 (month) (day) (year)
Cemetery or crematory: Farmwood Cemt
Location: Frostdale, Va
18. Funeral director: H. W. Pepperi
Address: Elkton, Md
19. May 9 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1945 at 3 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9 1945 to May 9 1945 and that I last saw h[illegible] alive on April 30 1945

	DURATION
Immediate cause of death: Convulsions	
Due to: Epilepsy	4 Mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James L. Johnson M.D. (M. D. or other)
Address: 232 E. High St. Elkton, Md Date signed: 5/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04909

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hrs.
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Elkton (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD 3 Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Peter Baran

3. (b) Social Security Number 215-22-7234

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh	Widowed

6.(b) Name of husband or wife: No Inf. 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Morley Mill
11. Industry or business:
FATHER 12. Name: No Inf.
13. Birthplace
MOTHER 14. Maiden name: No Inf.
15. Birthplace
16. Informant: Paul Bowulak
Address: Elkton R.D. 3, Md
17. Burial, (Burial, cremation, or removal. Which?) Date thereof: May 9/45 (month) (day) (year)
Cemetery or crematory: Chesapeake City Cathlic
Location: Chesapeake City, Md
18. Funeral director: W.W. Popkin
Address: Elkton, Md
19. May 9 19 45 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 19 45 at 9 20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 19 45 to May 5 19 45
and that I last saw h... alive on May 5 19 45

Immediate cause of death	DURATION
Coron Pneumonia	
Due to	
Due to	
Other conditions Mitral regurgitation	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Herbert Bahr M.D.
M. D. or other
Address: Elkton Md Date signed 5/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04910

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos. 1 day

Hospital, institution, or street address where death occurred:
Veterans Administration Facility

How long in hospital or institution? 7 mos. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Washington

City or town: Cecil
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box #242
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: BOLIN, Jacob H.

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Dorothy Bolin

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): January 6, 1896

8. AGE: Years	Months	Days	If less than one day
49	4	5	...hrs. ...min.

9. Birthplace: Pomeroy, Ohio (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: ---

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital records, Veterans Adminis-
Address: tration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 12, 1945 (month) (day) (year)

Cemetery or crematory: Oak Spring Cemetery,
Location: Canonsburg, Pa.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. May 12, 1945 (Date rec'd by registrar) Registrar: Irma E. Dunphy

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 1945 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10, 1944 to May 11, 1945 and that I last saw him alive on May 11, 1945

	DURATION
Immediate cause of death: Embolism, pulmonary	18 hrs.
Due to: Syphilis of the Central Nervous System, Meningo-Encephalitic type	over 7 mos.
Due to:	
Other conditions: Psychosis with syphilis of the C.N.S., Meningo-Encephalitic type (Include pregnancy within 3 months of death)	over 7 mos.

Major findings of operations: ---

Date of op.: --

Autopsy results: Embolism, pulmonary

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

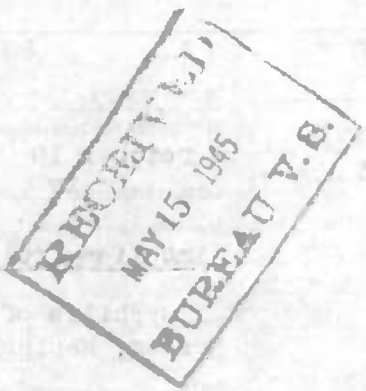
23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, Lt.Col., MC, Clinical Direc
Address: VAF, Perry Point, Md. Date signed: 5-12-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (128)

CERTIFICATE OF DEATH

~ 04911

Reg. Diat. No. 92

1. PLACE OF DEATH:
County Cecil
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md. County Cecil.
City or town Earlville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alice T. Bolton

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femal	White	married

6.(b) Name of husband or wife
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 1872

8. AGE: Years	Months	Days	If less than one day
73			hrs. min.

9. Birthplace Cecil Co Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John R. Taylor
13. Birthplace Md
MOTHER 14. Maiden name Millicent Slaughter
15. Birthplace Md
16. Informant James P. Bolton
Address Earlville Md.
17. Burial, cremation, or removal. Which?) Burial Date thereof May 21 1945 (month) (day) (year)
Cemetery or crematory Johnstown
Location Near Earlville Md
18. Funeral director Edward Fallon
Address Millington Md
19. May 19 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18 1945, at 8 20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/11 1945 to 5/18 1945 and that I last saw h alive on 5/17/45 1945

Immediate cause of death	DURATION
Acute Pancreatitis	1 wk
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. V. Donald M.D.
M. D. or other
Address Chesapeake Md Date signed 5/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8a)

CERTIFICATE OF DEATH

04912

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hrs.

Hospital, Institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rural Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles H. Brubaker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Edna Jane Brubaker

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1899

8. AGE: Years	Months	Days	If less than one day
46			hrs. min.

9. Birthplace: Lancaster Penna. (Town, county, and state)

10. Usual occupation: Inn Keeper

11. Industry or business

FATHER — 12. Name: John W Brubaker

13. Birthplace: Lancaster Co Penna

MOTHER — 14. Maiden name: Martha Jane Warfel

15. Birthplace: Lancaster Co Penna

16. Informant: Mrs. Charles W Brubaker

Address: Elkton 5, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 14 1945 (month) (day) (year)

Cemetery or crematory:

Location: Lancaster Penna

18. Funeral director: Joseph R Sharp

Address: North East, Md

19. May 12 1945 (Date rec'd by registrar) H B Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1945, at 2 12 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 1945 to May 12 1945 and that I last saw h... alive on May 12 1945

Immediate cause of death	DURATION
Cirrhosis of Kidneys	6 hours
Due to: Hypertension	
Due to:	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H A Cudwell M. D. or other

Address: North East Md Date signed: May 12 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (141-Q)

CERTIFICATE OF DEATH

04913

Reg. Dist. No. 72

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Mt Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Benjamin Cain

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 8 1945

8. AGE: Years | Months | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Elkton Cecil County, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: Reginald Farrar

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Mary Eliz. Cain

15. Birthplace: Port Deposit, Md.

16. Informant: Mary Eliz. Cain

Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 10 1945 (month) (day) (year)

Cemetery or crematory: Havanna Cemetery

Location: Harford Co. Md.

18. Funeral director: Wm A. Patterson & Son

Address: Perryville, Md.

19. May 9 1945 (Date rec'd by registrar) H H Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1945 at 1:52 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/8 1945, to 5/9 1945 and that I last saw him alive on 5/9 1945

Immediate cause of death	DURATION
Atelectasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: R L Dodson M.D. M. D. or other

Address: Rising Sun, Md. Date signed 5-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

F 04914

Reg. Dist. No. 95

1. PLACE OF DEATH:
County: Cecil
City or town: Conowingo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil Co.
City or town: Conowingo Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Vermella Carter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 2. 1940

8. AGE: Years | Months: 4 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Elkton, Cecil Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Arden Curtis
13. Birthplace: Va.

MOTHER
14. Maiden name: Violet Carter
15. Birthplace: Rowlandville, Md.

16. Informant: Violet Carter.
Address: Conowingo. Md. R. F. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29 1945 (month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Conowingo Md.

16. Funeral director: J E Tyson.
Address: Rising Sun Md.

19. 5/28 (Date rec'd by registrar) 19 45 Lem Worthington Registrar

Permit issued 5-28-45.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1945 at 11:30 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5/26 1945 to 5/27 1945 and that I last saw h... alive on 5/26 1945

Immediate cause of death	DURATION
Hemorrhage of bowels	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. H. Dodson M.D. M. D. or other
Address: Rising Sun Md. Date signed: 5/27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1 04915

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton 72 Hollingsworth Manor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Hollingsworth Manor #72

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

Street No. #72 Hollingsworth Manor
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Robert Church

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 23, 1943.

8. AGE: Years | Months | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Elkton, Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Carl William Church
13. Birthplace: Whitewood Va

MOTHER
14. Maiden name: Dorothy Clark
15. Birthplace: Frost / Ohio

16. Informant: Mrs Carl W. Church

Address 72 Hollingsworth Manor Elkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31/45 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton, Md

18. Funeral director: H. W. Pippen

Address: Elkton, Md

19. May 31 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 1945, at 1.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1945, to May 28 1945 and that I last saw h... alive on May 28 1945

Immediate cause of death	DURATION
(a) Uremia Nephritis	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James L. Johnson M.D.
M. D. or other

Address 23 E. High St, Elkton Date signed 5-31-45

M

VS A16 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

04916

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County Cecil
City or town Perryville, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Perryville, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Port Deposit road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Percy H. Claggett

3. (b) Social Security Number 216-09-4826

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hester B. Claggett
6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) July 2, 1899

8. AGE: Years 45 | Months 10 | Days 0 | If less than one day ... hrs. ... min.

8. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation Cashier
11. Industry or business National Bank

FATHER
12. Name Robert E. Claggett
13. Birthplace Montgomery Co. Md.

MOTHER
14. Maiden name Ida Watkins
15. Birthplace Montgomery Co. Md.

18. Informant Hester B. Claggett
Address Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6, 1945 (month) (day) (year)
Cemetery or crematory Pleasant Grove
Location Registerstown Balto Co. Md.
18. Funeral director Lewis Patterson & Son
Address Perryville, Md.

19. May 4 1945 Irma E. Doughaty
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1945 at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 24 1945 to May 2 1945 and that I last saw him alive on May 2 1945.

	DURATION
Immediate cause of death Cerebral Hemorrhage	4 mo.
Due to Hypertension with arterio-sclerosis	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. F. Magraw M. D. or other
Address Perryville Md. Date signed May 7 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04917

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 3 mo. 13 da.

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? ~~XXXXX~~ Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County: -

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 815 H Street, N.E.,
(If rural, give LOCATION)

2.(a) If veteran, name war: Philippine Insurrection ✓

3.(a) FULL NAME: CLARK, GROVER

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Isabelle T. Dunn

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1881

8. AGE: Years	Months	Days	If less than one day
63	6	22	- hrs. - min.

9. Birthplace: Richmond, Virginia
(Town, county, and state)

10. Usual occupation: Retired Civil Service Employee

11. Industry or business: -

FATHER
12. Name: Ogden H. Clarke
13. Birthplace: Richmond, Virginia

MOTHER
14. Maiden name: Annie Cora Griffith
15. Birthplace: Danville, Va.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 15, 1945 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. May 15 19 45 Irma E. Dunphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 19 45, at 12:45P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 31 1944, to May 14 1945 and that I last saw h im alive on May 14 1945

Immediate cause of death	DURATION
Cerebral Thrombosis with Softening of the brain	Over 1 year
Due to: Cerebral Arteriosclerosis	Over 1 year
Due to: Heart Disease, Cardiac Hypertrophy	Over 1 year
Other conditions: Psychosis with Cerebral Arteriosclerosis	Over 1 year

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: E. E. Hollinger
E. E. HOLLINGER, Lt. Col., M.C., Clinical Director, Veterans Administration

Address: Perry Point, Md. Date signed: 5-15-1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04918

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County Cecil
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo.
Hospital, institution, or street address where death occurred:
162 Hollingsworth Manor
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Cecil
City or town Elkton Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 162 Hollingsworth Manor E
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lewis Cochran

3. (b) Social Security Number

4. Sex M
5. Color or race Wh.
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Dec. 18, 1944

8. AGE: Years — Months 5 — Days 9 — If less than one day ... hrs. ... min.

9. Birthplace Elkton, Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name George W. Cochran
13. Birthplace Lester W. Va

MOTHER
14. Maiden name Helen Lewis
15. Birthplace Lester, W. Va

16. Informant Geo W. Cochran
Address Elkton 162 Hollingsworth Manor

17. Transportation Date thereof May 28/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Lester W. Va
Location Lester W. Va
18. Funeral director H. W. Pippin
Address Elkton, Md.

19. May 28 1945 F R Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 2 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1945, to May 27 1945
and that I last saw h— alive on May 26 1945

Immediate cause of death: Whooping cough — DURATION 3 wks.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Elkton
Date signed MAY 28 1945

MAY 28 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T

04917

Reg. Diat. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Chesapeake City, Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No. Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Wm Conner.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Married

6.(b) Name of husband or wife: Amelia Ott Conner.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 11. 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	2	29		

9. Birthplace: Cecil Co. Maryland (Town, county, and state)
10. Usual occupation: Retired Farmer.
11. Industry or business
FATHER — 12. Name: Joseph B. Conner
FATHER — 13. Birthplace: Cecil Co. Md
MOTHER — 14. Maiden name: Rachael Shehan
MOTHER — 15. Birthplace: Cecil Co Md.
16. Informant: Mrs. Amelia Ott Conner
Address: Chesapeake City, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12/45 (month) (day) (year)
Cemetery or crematory: Bethel
Location: Near Chesapeake City, Md
18. Funeral director: H. W. Fiphanie
Address: Elkton, Md.
19. May 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1945 at 1:45 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1945, to May 10 1945
and that I last saw h... alive on May 10 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	2 hours
Due to: Chronic Myocarditis	One Year
Due to: Overwork	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. V. Davis MD
M. D. or other
Address: Chesapeake City Md Date signed: 5/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

04920

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nick Mitchell Costides

3.(b) Social Security Number: 216-05-3866

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	married

6.(b) Name of husband or wife: no information

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 6 1895

8. AGE: Years	Months	Days	If less than one day
49	5	15	hrs. min.

9. Birthplace: Greece (Town, county, and state)
10. Usual occupation: Hotel clerk
11. Industry or business:
FATHER 12. Name: Michael Costides
13. Birthplace: Greece
MOTHER 14. Maiden name: Maria Vasiliadis
15. Birthplace: Greece
16. Informant: Mrs Rose McNabb
Address: Elkton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 24 1945 (mouth) (day) (year)
Cemetery or crematory: Elkton Cemetery
Location: Elkton Md
18. Funeral director: H C Pepper
Address: Elkton Md
19. May 24 1945 (Date rec'd by registrar) E R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1945 at 8.15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: R L Woodall M.D. Medical Examiner for Cecil County
Address: Elkton Md. M. D. or other. Date signed: 5-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

04921

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 5-7 years

Hospital, Institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton R. D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jeanette Galt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1878 March 15

8. AGE: Years: 67 | Months: 2 | Days: 9 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Ill. (Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER — 12. Name: Thomas Galt

13. Birthplace: Springfield Ill

MOTHER — 14. Maiden name: Jeanette McFarlane

15. Birthplace: Glasgow Scotland

16. Informant: Hospital Records

Address: Union Hospital, Elkton Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 28, 1945 (month) (day) (year)

Cemetery or crematory: Spring Lake Cemetery

Location: Aurora Illinois

18. Funeral director: W. W. Pippin Burial Assn.

Address: Elkton Md

19. May 26 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1945, at 2.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 1945, to May 24 1945

and that I last saw her alive on May 24 1945

Immediate cause of death	DURATION
Myocarditis	
Due to: Friedreich's ataxia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Herbert Bates M.D.

M. D. or other

Address: Elkton Md Date signed: 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170

CERTIFICATE OF DEATH

04922

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Amelia Marie Guetschow. | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 19 1931

8. AGE:

Years	Months	Days	If less than one day
14	3	7.	hrs. min.

9. Birthplace: Chesapeake City Md. (Town, county, and state)

10. Usual occupation: School Girl.

11. Industry or business:

FATHER — 12. Name: Hebert Guetschow

FATHER — 13. Birthplace: Baldern, Pris.

MOTHER — 14. Maiden name: Hattie Potter

MOTHER — 15. Birthplace: Pennsylvania

16. Informant: Hebert Guetschow

Address: North East R.D.1 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29 1945 (month) (day) (year)

Cemetery or crematory: Oxford

Location: Oxford, Pa.

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. May 28 1945 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1945, at 1230 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Electrocuted	
Due to: Shock.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of injury: 5/26-45

Where did injury occur? North East Cecil Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Route 7.

Means of injury: Automobile Injured at work?

23. SIGNATURE: R. E. Dodson M.D. Medical Examiner Cecil County

Address: Rising Sun Md. M. D. or other Date signed: 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

(4923

Reg. Dist. No. 96

1. PLACE OF DEATH:
County Cecil
City or town Charlestown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Charlestown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Lee Haines

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Harry L. Haines
6.(c) If alive, give age: 76 years
7. Birth date of deceased (mo., day, yr.): March 7 1879
8. AGE: Years 66 Months 1 Days 28 If less than one day: hrs. min.
9. Birthplace: Charlestown Cecil co. Md. (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:
12. FATHER — Name: Richard H. Richardson
13. FATHER — Birthplace: Cecil co. Md
14. MOTHER — Maiden name: Louisa Thompson
15. MOTHER — Birthplace: Cecil co. Md
16. Informant: Harry L. Haines
Address: Charlestown, Md.
17. (Burial, cremation, or removal—Which?) Burial * Date thereof: May 8, 1945 (month) (day) (year)
Cemetery or crematory: Charlestown
Location: Charlestown, Md
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. May 8 1945 (Date rec'd by registrar) Irene E. Dwight Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1945 at 9 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr 21 1945 to May 5 1945 and that I last saw h[illegible] alive on May 4 1945
Immediate cause of death: Cerebral Hemorrhage — DURATION: 2 wks.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. B. Collins, M.D.
M. D. or other
Address: North East, Md. Date signed: 5-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04924

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mo. 27 days

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2119 H Street, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: HALE, IRVINE R.

3.(b) Social Security Number: 77-18-3232

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: Evelyn (?) Hale

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 25, 1897

8. AGE: Years	Months	Days	If less than one day
47	6	6	... hrs. ... min.

9. Birthplace: Knoxville, Tennessee (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: -

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-17-45 (month) (day) (year)

Cemetery or crematory: Greenwood Cemetery

Location: Knoxville, Tennessee

18. Funeral director: Pennington & Son

Address: Pennington & Son, Havre de Grace, Md.

19. May 17 (Date rec'd by registrar) 19 45 Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 19 45 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 19 44 to May 16 19 45 and that I last saw him alive on May 16 19 45

Immediate cause of death	Duration
Coronary Occlusion	24 hrs.
Due to: Coronary Arteriosclerosis	App. 1 yr.
Due to: Myocardial Damage	App. 6 mo.
Due to:	
Other conditions: -	

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op. ...

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: C. E. Trollinger TROLLINGER, Lt. Col., M.C. Clinical Director M. D. or other

Address: Perry Point, Md. Date signed: 5-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18, Md.

T 4925

CERTIFICATE OF DEATH

Reg. Diat. No. 46

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME John W. Haaaan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widowed

6.(b) Name of husband or wife: Eva M. Haaaan
deceased
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 2 1875

8. AGE: Years	Months	Days	If less than one day
70	3	13	hrs. ..... min.

9. Birthplace: Port Deposit Cecil Co. Md.
(Town, county, and state)
10. Usual occupation: Mail Carrier
11. Industry or business: U. S. Mail

FATHER
12. Name: Abraham Haaaan
13. Birthplace: Cecil Co. Md.

MOTHER
14. Maiden name: Elizabeth Kelley
15. Birthplace: Cecil Co. Md.

16. Informant: Edward Haaaan
Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1945 (month) (day) (year)
Cemetery or crematory: Lafferell
Location: Port Deposit Md. Rural

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. May 17 1945 Registrar: Irma E. Daugherty
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1945, at 8A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1945, to May 14 1945
and that I last saw him alive on May 14 - 1945

Immediate cause of death	DURATION
Chronic Myocarditis	.5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. J. Johnson M. D.
M. D. or other
Address: Port Deposit Md. Date signed 5/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43)

CERTIFICATE OF DEATH

74925

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CECIL

City or town: BAINBRIDGE, MARYLAND.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months 25 days

Hospital, institution, or street address where death occurred: U.S. Naval Hosp. NavTraCen., Bainbridge, Maryland.

How long in hospital or institution? 2 months - 16 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: VIRGINIA County: Southampton

City or town: BOYKINS
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. # 2. Box 100.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: Robert Lee JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Marie Barnes JOHNSON

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): May 10, 1925

8. AGE: Years	Months	Days	If less than one day
20	0	20	....hrs. ....min.

9. Birthplace: Branchville, Virginia.
(Town, county, and state)

10. Usual occupation: Farm hand

11. Industry or business: ----

FATHER
12. Name: Robert JOHNSON
13. Birthplace: Unknown

MOTHER
14. Maiden name: Marie ROLLINS
15. Birthplace: Unknown

16. Informant: U.S. Naval Hosp. NavTraCen., Bainbridge, Md.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 31, 1945 (month) (day) (year)

Cemetery or crematory

Location: To, Boykins, Virginia

18. Funeral director: Chas. Patteson & Son

Address: Berryville, Md.

19. May 31 1945 Irma E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 19 45, at 4:06 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 19 45, to May 30 19 45 and that I last saw h.i.m. alive on May 29 19 45

Immediate cause of death	DURATION
Blastomycosis, Generalized	3 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Proved diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harry C. Dard M.D.
M. D. or other

Address: U.S. Naval Hospital Bainbridge Md. Date signed: 30 May 1945.

04927

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:
County: Cecil
City or town: Rising Sun Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Rising Sun Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: David Allen Lewis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): October 10 1941

8. AGE: Years: 3 | Months: 6 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Rising Sun Rural (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: George A. Lewis
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Legg
15. Birthplace: Lebanon Penna

16. Informant: Mrs. Mary Lewis
Address: Rising Sun Route 1, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9 1945 (month) (day) (year)
Cemetery or crematory: Bay View Methodist
Location: Bay View, Maryland

18. Funeral director: Joseph R. Groth
Address: North East Md

19. 5/10 1945 Lia V. Evans
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
General Septicemia	
Due to: Impetigo Contagiosa	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md Date signed: 5-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04928

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Rural Near Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years.
Hospital, institution, or street address where death occurred: Elkton R.D 3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Rural Near Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Elkton R.D 3
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Michael Sickowid.

3. (b) Social Security Number 221-07-9563

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Married.

6.(b) Name of husband or wife: Anna Sickowid
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Oct 3, 1880

8. AGE: Years	Months	Days	If less than one day
64	7	18	...hrs. ...min.

9. Birthplace: Gloria Austria
(Town, county, and state)
10. Usual occupation: Meat Cutter
11. Industry or business

FATHER
12. Name: Theodore Sickowid.
13. Birthplace: Austria

MOTHER
14. Maiden name: Not Known.
15. Birthplace

16. Informant: Anna Sickowid.
Address: Elkton R.D. 3 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 24/45 (month) (day) (year)
Cemetery or crematory: St Mary's (Ivy Close)
Location: Elkton Md
18. Funeral director: H. W. Pippin
Address: Elkton, Md
19. May 22 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1945 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Coronary	
Due to: Hypostatic	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. H. Woodward M.D. Medical Examiner Cecil County
Address: Rising Sun Md. M. D. or other
Date signed: 5-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17a)

CERTIFICATE OF DEATH

T 04929

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Hallwgarwith Manor

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Austin L. Marcus

3. (b) Social Security Number: 215-10-7419

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Sybil Marcus

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 17, 1911

8. AGE: Years: 34 Months: 1 Days: 27 If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Chauffeur for State Roads Comm.

11. Industry or business:

FATHER — 12. Name: James Marcus

FATHER — 13. Birthplace: Elkton, Md.

MOTHER — 14. Maiden name: Leora Ferguson

MOTHER — 15. Birthplace: Elkton, Md.

16. Informant: Mrs. Austin Marcus

Address: Elkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/45 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton, Md.

18. Funeral director: H. W. Pippin

Address: Elkton, Md.

19. May 15 1945 (Date rec'd by registrar) H R Teague Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945 at 9:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1945 to May 13 1945 and that I last saw him alive on May 13 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Paralysis	
Due to Acute bladder disorder	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Cystoscopic examination

Date of op. May 11, 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] Caldwell, M.D.

M. D. or other

Address: May 14/45 North Court Date signed 5/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

T 04930

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: N C County: Cab.
City or town: Lansing
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Vendal Allan Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Nov. 29. 1932.

8. AGE: Years 12. Months 5 Days 5 If less than one day ... hrs. ... min.

9. Birthplace Lansing N. C.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Granville Miller
13. Birthplace Lansing N C

MOTHER
14. Maiden name Myrtle Stansbery
15. Birthplace Lansing N C

16. Informant Granville Miller
Address Port Deposit Md.

17. Burial Date thereof May 14, 1945
(Burial, cremation, or removal. Which?) (Month) (day) (year)
Cemetery or crematory West Nottingham
Location Colora, Md. Rural

18. Funeral director Lee A. Patterson & Son
Address Perryville, Md.

19. May 14 1945 Irene E. Douglass
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Drowned.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5-2-45
Where did injury occur Port Deposit (City or town) Cecil (County) Md (State)
Injured at home, farm, industry, public place (where?) Susquehanna River
Means of injury Boat Capsized Injured at work?

23. SIGNATURE R. L. Dodson M.D.
Medical Examiner
Cecil County
M. D. or other
Address Rising Sun Md. Date signed 5-3-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79)

CERTIFICATE OF DEATH

04931

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Carroll

City or town: Eldersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hospital Elkton Md

How long in hospital or institution? 2 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Same

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Franklin Orr.

3.(b) Social Security Number: 213-03-0598

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Ella Orr.

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): March 3 1872.

8. AGE: Years: 73 | Months: 2 | Days: 20 | If less than one day: ...hrs. ...min.

9. Birthplace: Port Deposit Md (Town, county, and state)

10. Usual occupation: Store Keeper.

11. Industry or business: Hard ware Store

FATHER — 12. Name: Evan Orr.

13. Birthplace: —

MOTHER — 14. Maiden name: Mary Eliz Whitelock

15. Birthplace: —

16. Informant: Ella Orr.

Address: Rising Sun Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/27-45 (month) (day) (year)

Cemetery or crematory: Hopewell Cemetery

Location: Port Depost Md.

18. Funeral director: Ralph M Reed.

Address: Rising Sun Md.

19. May 25 1945 (Date rec'd by registrar) F H Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1945 at 10 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5/17 1945, to 5/23 1945 and that I last saw h... alive on 5/23 1945

	DURATION
Immediate cause of death: Gangrene of left leg below knee	
Due to: Emboli.	
Due to: Thrombosis of left femoral artery	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Thrombosis of left femoral artery. Date of op. 5/21-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ralph Reed M.D.

M. D. or other

Address: Rising Sun Md. Date signed: 5/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

04932

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137a

CERTIFICATE OF DEATH

Reg. Dist. No. 95

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Cecil
City or town: Zion
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Zion
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) —
2.(a) If veteran, name war

3. (a) FULL NAME John William Prettyman
3. (b) Social Security Number none

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Grace C. Prettyman
6.(c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): Nov 14 1864
8. AGE: Years 80 Months 6 Days 0 If less than one day ... hrs. ... min.
9. Birthplace: near Laurel, Sussex Co Del
(Town, county, and state)
10. Usual occupation: Minister
11. Industry or business
FATHER 12. Name: Bagwell Parker Prettyman
13. Birthplace: Del
MOTHER 14. Maiden name: Lavina Bryan
15. Birthplace: Del
16. Informant: Mrs John W. Prettyman
Address: North East R D, Md
17. Burial Date thereof: May 17-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Rosebank
Location: Calvert Md
18. Funeral director: Joseph R. Evans
Address: North East, Md
19. 5/16 19 45 L M Northum Registrar
(Date rec'd by registrar)

Permit issued 5-16-45 J

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1945, at 11:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1944, to May 14 1945
and that I last saw him alive on May 14 1945

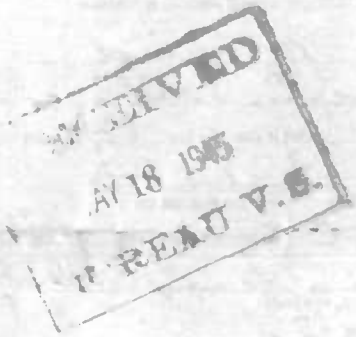
	DURATION
Immediate cause of death: Pyelonephritis	9 months
Due to:	
Due to: Enlarged prostate & cystitis	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Removal of prostate
Date of op. June 24 44
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Guy S. Holcomb M. D. or other
Address: Elkton Md Date signed: May 15 44

VS A15


RECEIVED
MAY 18 1965
BUREAU V.S.

Evidence for change of age is shown on FILM No. G 95 MAY 29 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

T 04933

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Principio Furnace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah MaE Neiser

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Robert Neiser
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct 19 1888

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56 -5-7-	6	22		

9. Birthplace: Cecil Co Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: William G. McKinney
13. Birthplace: Md
MOTHER 14. Maiden name: Mary E Robinson
15. Birthplace: Md
16. Informant: Mrs Calvin N. Walbeck
Address: Charlestown, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15 1945 (month) (day) (year)
Cemetery or crematory: Methodist
Location: North East, Md
18. Funeral director: Joseph R Sears
Address: North East Md
19. May 14 1945 Irene E. Dunbar (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1945, at 5:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 12, 1945 to May 11 1945
and that I last saw her alive on May 11, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Days Hrs. Mins.
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James L. Johnson M.D. (M. D. or other)
Address: 232 E. High St. Elkton Md Date signed: 5/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

04934

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County CECIL
City or town Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2-2/3 months
Hospital, institution, or street address where death occurred: US Naval Hosp-ital, NavTraCenter, Bainbridge, Maryland.
How long in hospital or institution? 1-2/3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Florida County Bay
City or town St. Andrew, Florida.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Box 94
(If rural, give LOCATION)
2.(a) If veteran, name war WORLD WAR II ✓

3.(a) FULL NAME John Oliver P O U N C Y, Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	SINGLE

6.(b) Name of husband or wife: Not married
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 31 May, 1927

8. AGE: Years	Months	Days	If less than one day
17	11	22	..... hrs. ..... min.

9. Birthplace Lockart, Alabama (Town, county, and state)
10. Usual occupation US Navy
11. Industry or business
12. FATHER — Name John Oliver POUNCY, Sr
13. FATHER — Birthplace Unknown
14. MOTHER — Maiden name Unknown
15. MOTHER — Birthplace Unknown
16. Informant US Naval Hosp. NavTraCenter
Address Bainbridge, Maryland.
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 24, 1945 (month) (day) (year)
Cemetery or crematory Pt. Pangma City, Bayes, Florida
Location
18. Funeral director Lee A. Patterson & Son
Address Perryville, Md
19. May 24 1945 Irma E. Dunfee (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 May, 1945, at 1223 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4/3/1945 to 5/23 1945
and that I last saw him alive on 5/23/1945

	DURATION
Immediate cause of death: General Peritonitis	7 wks
Due to: Acute Appendicitis	7 wks
Due to:	
Other conditions: Gas Bacillus infection Abdomen	6 wks

(Include pregnancy within 3 months of death)

Major findings of operations: Acute Appendicitis, welt gen'l Peritonitis Date of op. 4/3/45
Autopsy results: Gen'l Peritonitis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. Frederic Dreyer. M. D. or other
Address Lt. Comdr. U.S.N.R. Date signed 5/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

64935

Reg. Dist. No. 95

1. PLACE OF DEATH:
County Cecil
City or town Rising Sun Rural.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Rising Sun R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Joe Shumate

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31. 1942

8. AGE: Years | Months | Days | If less than one day ... hrs. 30 min.

9. Birthplace Rising Sun. Md. R.F.D. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Claude Day Shumate
13. Birthplace North Caholina

MOTHER 14. Maiden name Evelyn Dare Osborne
15. Birthplace Grassy Creek, North Carolina

16. Informant Claude Shumate
Address Edgewood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1 1945 (month) (day) (year)
Cemetery or crematory Baptist Cem.
Location Conowingo Md.

18. Funeral director J. E. Tyson.
Address Rising Sun Md

19. 6/1- 1945 L M Washington
Date rec'd by registrar Registrar

Permit issued 6-1-45

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945 at 6.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/31 1945 to 5/31 1945
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Premature infant	
Due to Multiple gestation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. L. Dodson M.D. M. D. or other
Address Rising Sun Md Date signed 6/3/-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-2)

CERTIFICATE OF DEATH

04936

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil County, Maryland
City or town: Elkton, R.D. 3, (Barkesdale)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Del. County: New Castle
City or town: Newark
(If outside city or town limits, write RURAL and give nearest town)
Street No.: North Chapel
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Walter Van Sant

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Sarah Vansant
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Sept 22 - 1903

8. AGE: Years: 41 | Months: 7 | Days: 23 | If less than one day: ...hrs. ...min.

9. Birthplace: McClenahville Del
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: Oliver Vansant
13. Birthplace: Del

MOTHER
14. Maiden name: Mamie Von Del Lehr
15. Birthplace: Del

16. Informant: Mrs Sarah Vansant
Address: 74 N. Chapel St Newark Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18 1945 (month) (day) (year)
Cemetery or crematory: Ebenezer Del
Location: Newark Del R.D.

18. Funeral director: R.T. Jones
Address: Newark, Del

19. May 16 1945 (Date rec'd by registrar) F.R. Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15, 1945, at 1:30P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to May 15 1945
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to: Alcoholism	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard H. Boucher, M.D.
Acting Coroner. M. D. or other
Address: Elkton, Md. Date signed: 5/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04937

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ten days
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 518 N. Adams Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: WIGLEY, John Harry

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Hester J. Wigley
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): November 16, 1887

8. AGE: Years	Months	Days	If less than one day
57	6	20	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: --

FATHER
12. Name: Richard Wigley
13. Birthplace: Baltimore Co., Md.

MOTHER
14. Maiden name: Emma Weckiser
15. Birthplace: Baltimore Co., Md.

16. Informant: Mrs. Hester J. Wigley - wife
Address: 518 N. Adams St., Havre de Grace, Md.

17. May 7, 1945 Burial (Burial, cremation, or removal. Which?) Date thereof May 7, 1945 (month) (day) (year)
Cemetery or crematory: Angel Hill Cemetery
Location: Havre de Grace, Md.

18. Funeral director: Pennington & Son / PENNINGTON & SON
Address: Havre de Grace, Md.

19. May 7, 1945 (Date rec'd by registrar) Registrar: Irma E. Haught

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5, 1945, at 10:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26, 1945, to May 5, 1945 and that I last saw him alive on May 5, 1945

Immediate cause of death	DURATION
Tuberculosis, pulmonary	20 yrs.
Pneumonia, lobar, right	10 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op.: --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: Injured at work?

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, Lt. Col., M.C., Med. Director
Address: VAF, Perry Point, Md. Date signed: 5-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 04485

1. PLACE OF DEATH:
County: Cecil
City or town: RD #1 - North East, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 46 yrs
Hospital, Institution, or street address where death occurred:
St. Home - Calvert, Md.
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: RD #1 - North East, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. -
(If rural, give LOCATION)
2.(a) If veteran, name war -

3. (a) FULL NAME: Willett Cameron Yerkes

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Myra K. Yerkes
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): November 4, 1888

8. AGE: Years	Months	Days	If less than one day
56	6	6	...hrs. ...min.

9. Birthplace: Oxford Penna - R.D. (Town, county, and state)
10. Usual occupation: Butcher
11. Industry or business:

FATHER
12. Name: James M. Yerkes
13. Birthplace: Nottingham, Pa. R.D.

MOTHER
14. Maiden name: Margaretta Cameron
15. Birthplace: Nottingham, Pa. R.D.

16. Informant: Mrs Virginia Yerkes
Address: RD #1 - North East, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 1945 (month) (day) (year)
Cemetery or crematory: Rose Banks
Location: Calvert, Md.

18. Funeral director: J. E. Tyson
Address: Rising Sun Md.

19. May 12 1945 (Date rec'd by registr.) Registrar

Permit issued 5-12-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1945 at 1.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-1 1943 to 5-10 1945 and that I last saw h[illegible] alive on 5-9 1945

Immediate cause of death	DURATION
Carcinoma of Colon.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: R. E. Dodson M.D. (M. D. or other)
Address: Rising Sun Md. Date signed 5/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

64939 T

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 days

Hospital, Institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rural Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Elkton RD 5 Md

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Maria Zahn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel Zahn

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 16 1872.

8. AGE: Years	Months	Days	If less than one day
71	3	15	..... hrs. ..... min.

9. Birthplace: Paris S. Russia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Jacob Schmierer

13. Birthplace: Paris So. Russia

MOTHER — 14. Maiden name: Christina Mondi

15. Birthplace: Paris South Russia.

16. Informant: Christina Zahn

Address: Elkton R.D. 5 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 4 1945 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton Md

18. Funeral director: H. L. Pippin

Address: Elkton, Md

19. May 4 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1945 at 7-45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 7, 1945, to May 1 1945 and that I last saw h.. alive on May 1, 1945

Immediate cause of death	DURATION
Diabetes Gangrene of foot	3 months
Due to: Diabetes Mellitus	unken
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. W. Davis M.D.

M. D. or other

Address: Chesapeake City, Md. Date signed: 5/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A13